Date: Thursday March 14, 2013
Written Legislative Testimony to the Public Health Committee
Regarding: Raised S.B. No. 993, *An Act Concerning Dental Assistants and Expanded Function Dental Auxiliary*
Submitted by: Kristin Minihan-Anderson, RDH, MSDH

Senator Gerratana, Representative Johnson, Senator Slossberg, Representative Miller, and Members of the Public Health Committee,

My name is Kristin Minihan-Anderson. I am writing to oppose S.B. 993 as it is currently written and support the ADHP language from last years legislative session be added (H.B. 5541 2012) .

I have practiced dental hygiene in the State of Connecticut for 21 years. I have been in the dental health care field for 29 years; initially as an orthodontic assistant, certified orthodontic assistant, then a dental hygienist. Working in orthodontic, general dentistry, public health, and educational settings has allowed me to gain insight regarding the role of each member of the dental health care team and how it relates to the delivery of effective, efficient, safe, and complete client treatment. My current positions are as a clinical dental hygienist in private practice, Clinical Assistant Professor teaching Ethics, Juresprudence and Dental Hygiene Practice Management, Dental Materials Lab, Advanced Clinical Concepts, Master Degree Concentrated Practicum Advisor, and I am the Supervisor of the Fones Dental Hygiene Health Center at Tisdale Elementary School.

When developing changes to our program, we utilized existing research that supports the provision of preventive oral health care in a school setting. School-based dental health care clinics exist in settings where the student population has been determined to be at high risk for oral disease. Poor oral health can lead to decreased school performance, poor social relationships, and less success later in life. Additionally, children experiencing oral pain are distracted and unable to concentrate on schoolwork (U.S. GAO 2000). As estimated 51 million school hours per year are lost because of restorative dental visits and oral health problems (Gift, HC., Reisine, ST,. Larach, DC. 1992). When children's oral health problems are treated and they are not experiencing pain, their learning and school attendance records improve (Gift, HC., et al. 1992).

My previous experiences provided me with the background necessary to evaluate our existing preventive oral health program here at Tisdale and implement necessary changes. The appointment procedure we had in place previously consisted of bringing children in for multiple short visits to attempt to meet their assessed needs and accommodate class schedules. As a result of our program evaluation, it was determined that we were not meeting our expected outcomes. This lead to the implementation of dramatic changes to our daily process of care and appointment procedure in September 2011. The changes ensure that each child who is a client of our clinic receives *complete preventive services* in one visit when possible. All assessed needs are met in that visit. Following our full health and oral health assessment (including review of risk factors), if the child requires a full mouth debridement with ultrasonic instrumentation, debridement with hand instrumentation, oral prophylaxis, recording of plaque, oral hygiene, and periodontal classifications, restorative charting, intra and extraoral examination of the tissues of the head and neck, clinical examination, DIAGNOdent caries laser scan, fluoride treatment, intraoral radiographs, pit and fissure sealant placement, and referral to collaborating members of the child's health care team.

The Connecticut Department of Public Health Office of Oral Health published the findings of their 2011 Every Smile Counts research (2012). Although progress has been made, dental decay remains a prevalent problem for a majority of children in particular areas of Connecticut. It is important to note that the demographic sample utilized for this study is not consistent with the population that would be addressed in a public health setting and considered underserved. The sample used was approximately 75% white and 14 % black. I provided the descriptive statistics for 2011-2012 for the Fones Dental Hygiene Health

Center at Tisdale, which a truer representation of the populations that are underserved and would be addressed by the implementation of the ADHP. A Tisdale we have a 45% rate of untreated decay and 68.4% of the children referred for restorative intervention DID NOT have the work done when re-screened. ***This is the problem, the lack of restorative intervention is catastrophic to the well being of these children.*** Furthermore, when the Director of the Office of Oral Health for the Connecticut Department of Public Health presented these results on September 12, 2012 at the 7th Annual Rural Oral Health Conference, it was stated that the survey findings "under-representation of decay prevalence" because the methodology of the exam does not include radiographs and instruments such as explorers. It is just a visual examination, only requiring eyesight.

I strongly urge you to amend S.B. Bill 993 to include language for the Advanced Dental Hygiene Practitioner. The main reason I oppose the existing bill is because it fails to address access to care in general, but especially a public health setting. ***The Expanded Function Dental Assistant (EFDA), as proposed under SB 993, works under the direct supervision and control of a dentist.*** It has already been established EXTENSIVELY by evidence based research that dentists are not providing substantial care in the settings that provide access to care for the underserved. The EFDA is not permitted to administer local anesthesia or prepare a tooth for a restoration. This will not effectively address the overwhelming oral health issues related to public health settings. **The dental associations argument that an EFDA will help them increase their ability to see more clients, thus allowing them to further address the access to care issue is nullified by research presented by the Pew Center on the States (2010). In their publication *It Takes a Team: How New Dental Providers Can benefit Patients and Practices*, results indicate that by adding 1 ADHP to a solo pediatric practice will increase profits by 54% and productivity by 51%. In a general practice setting, adding 1 ADHP will increase profit by 52% and productivity by 51%.** No other provider model even comes close to this. Although, the ADHP model being proposed here in Connecticut is solely for public health settings, the dental associations argument to use an EFDA in a private practice setting is moot. **If the dental association really wanted to have an impact within a private practice setting they would listen to the research and propose the ADHP as the solution.** A dental hygienist and ADHP CANNOT open an independent practice in the State of Connecticut. Only dentists and public health entities can employ these individuals.

The ADHP will effectively provide care to the underserved in public health settings while utilizing a collaborative agreement to refer clients for restorative work and conditions beyond the very succinct scope of practice applied to this provider. Additionally, the ADHP model is built upon the strong preventive foundation of the dental hygienist. Only the ADHP model provides a professional who can FULLY address the preventive (including periodontal debridement) needs of the client in addition to completing the approved restorative services. THIS is meaningful and effective care. Future prevention of disease is key in public health settings. The ADHP brings with them the extensive oral/systemic educational background allowing for not only the planning and delivery of individualized care plans but also population based solutions. **The ADHP will save Medicaid, uninsured and insured individuals money because they intervene early in the disease process eliminating the need for costly treatment plans resulting from lack of early restorative care. The ADHP is the ONLY provider who is a VIABLE solution to the problem.**

The Congressional Budget Office publication *Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act* (2012) outlines the impact this will have on the influx of individuals qualifying for dental coverage. If the State of Connecticut does not address the access to care issue now by adding ADHP's to their dental provider model, it will experience a crisis of epic proportions. The medical community is already preparing for this impact, but only the dental hygienists of this state are voicing a viable solution to this impending problem here in Connecticut. It is of the utmost importance that you, as legislators, listen and act now.

I implore you to not only review the current evidence based research regarding the hygiene-based mid-level provider but to embrace the national movement towards this provider. All the research supports this

provider. This provider is the ONLY model that provides **full preventive care including periodontal debridement and the succinct restorative care** outlined in the scope of practice, but is the most cost effective and productive model available. It is the provider model to support if you truly want to address the lack of care faced by the dentally underserved in the State of Connecticut.

Thank you for your time and attention,

Kristin Minihan-Anderson, RDH, MSDH

DESCRIPTIVE STATISTICS
2011-2012
FONES DENTAL HYGIENE HEALTH CENTER
AT
TISDALE ELEMENTARY SCHOOL

SERVICE	2010-2011 TOTAL	2011-2012 TOTAL	DIFFERENCE (+/-)
Prophy; exam, fl2	275	346	+71
Radiographs (number of children receiving service)	97	252	+155
DIAGNOdent (number of children receiving service AND sealants)	94	297	+203
Sealants (number of teeth sealed)	293	2103	+1,810
Visits to clinic (visits include prophy, radiographs, emergency exams and support service visits)	334	476	+142

NUMBER OF CHILDREN REGISTERED AT FDHHC at TISDALE	
Registered at FDHHC	391
Treated at FDHHC 2011-2012 * 16 were seen twice for ProC	330
Treated at their Dental Home 2011-2012 * Tracked through the CTDHP Dental Record webpage, continue to monitor recall status at dental home	61
Rate of Student Attrition 2011-2012 * Clients no longer attending Tisdale	39

Descriptive Statistics Breakdown 2011-2012
FDHHC at Tisdale Elementary School

Total Visits to Clinic 476
- Prophy (complete cleaning) 346
- New Patient exam 155
- Recall exam 191
- Emergency Exam 30
- Separate dental sealant visits 100
- Full debridement (scaling full mouth) 123
  - Pain mgmt./topical anesthetic 15

Sealants:
- **Total** **2,103**
  - Primary molar 729
  - Premolar 650
  - Permanent molar 724

Radiographs
- **Total children receiving service** 252
  - FMX 1
  - 2 Bitewings 120
  - 4 Bitewings 131
  - Periapicals 100

Incidence of Decay
Total number of teeth with decay: 497

D	M	F	DMF TOTAL		d	e	f	def total
256	6	234	492		241	47	244	544

Referrals
- **Total** **164**
  - Restorative 154
  - Orthodontic 6
  - Medical 1
- ✓ **44.5% of children had decay**

Insurance

• Private	33	9%
• No insurance	60	17%
* **5.8%** of children treated at FDHHC at Tisdale are uninsured		
• Medicaid (CTDHP)	257	74%
* Ineligible: **11.6%** of children enrolled in Medicaid but are not currently eligible for coverage by medical/dental providers	22	

This means 60% (n=235) are covered by Medicaid Dental and
21% (n=82) are uninsured